**Simulation Scenario - Renal Colic**

Points to hit on (abd/GU/gyn assessment, medical directive, blood draw, IV insertion, approaching MD for analgesia orders)

Presenting patient dressed. No history volunteered but will answer questions when asked

38 year old female with 2 hour history of LLQ abd pain, nauseated, restless. Previously healthy

Last BM unsure, thinks 2 days ago. Not regular

LMP 2 wks. ago, denies vaginal bleeding/discharge. Using birth control

Urine concentrated; very restless, sweating, Has 3 kids

O- 2 hours ago; took 2 ES Tylenol and 2 Advil – it’s not helping

P – nothing

Q – wave-like;

R – radiates to flank

S – at its worst, is 10/10 – pain as bad as childbirth; “pain is making me vomit”; can’t get comfortable, too painful to drive here”

T – ongoing

Allergic to Naprosyn and aspirin. Bowel sounds active, abdomen soft and obese

Ensure nurse is able to complete vital signs, full abd assessment, draw blood for suspected renal colic and insert IV

Vital signs: T 37.3 HR 99 RR 20 BP 148/86 SpO2 96 RA. While nurse assessing patient, patient has episode of pain – “I gotta get up” “I can’t just lay here….it hurts so bad”. Patient vomits.

Patient continues to moan in pain……hopefully triggering the nurse to seek MD order for analgesia. Dr. gives order for Dilaudid 1 mg IV – which nurses proceeds to give.

**Observer 1 Checklist: Lower Abdominal Pain**

Learning Objectives:

1. Complete abdominal assessment in patient
2. Recognize criteria and initiate blood sampling and IV insertion medical directive associated with abdominal pain when appropriate
3. Demonstrates initiative to collaborate with MD for pain control

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y** | **N** | **Comments** |
| Hand hygiene |  |  |  |
| Introduced self; undressed patient |  |  |  |
| Completed full set of vital signs  Attached pulse oximetry |  |  |  |
| Took patient history |  |  |  |
| ABCD assessment |  |  |  |
| Abdominal assessment |  |  |  |
| Pain assessment: OPQRST |  |  |  |
| Identified need to initiate medical directive |  |  |  |
| Obtained blood sample |  |  |  |
| Inserted intravenous using approved technique |  |  |  |
| Reassessed after pain episode: Vital signs, attached to monitor, OPQRST |  |  |  |
| Notified MD |  |  |  |
| Requested analgesia order from MD |  |  |  |
| Other observations |  |  |  |

**Observer 2: Team Communication Checklist**

Objectives:

1. Demonstrates clear communication with team members including closed loop communication
2. Demonstrates understanding and use of team resources

|  |  |  |  |
| --- | --- | --- | --- |
| **Team Members** | **Y** | **N** | **Comments** |
| Communication is concise, clear and specific |  |  |  |
| Seeks information from all resources, including patient/family and RT |  |  |  |
| Verifies that information is correct |  |  |  |
| Notified MD and was able to give report of patient using SBAR tool: |  |  |  |
| Situation |  |  |  |
| Background |  |  |  |
| Assessment |  |  |  |
| Recommendations |  |  |  |
| Additional observations |  |  |  |

**Observer 3: Team dynamics**

1. List examples of effective communication you observed during this scenario (including closed loop communication).
2. Have you observed times in which communication was unclear and you did not observe closed-loop communication? If so, provide examples and explained how the closed loop communication would have improved the scenario.
3. Were appropriate care providers notified in a timely fashion and was the nurse able to provide a history of patient presentation and events occurring in the ED?

Was the SBAR tool implemented?

**Observer 4: Assessment Observations of RN 1**

1. Were key assessment and interventions organized and prioritized appropriately?
2. Describe collaboration efforts of RN 1 with RN 2
3. Describe reassessment completed when patient had episode of pain/hypotension
4. Describe communication between RN 1 and MD upon deterioration of patient.